Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003497	A. BUILDING _____ B. WING _____	07/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL AMBULATORY SURGERY CENTER LLC, THI	13421 OLD MERIDIAN ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of a State complaint. Complaint Number: IN00104808 Unsubstantiated: lack of sufficient evidence Date: 7/19/12 Facility Number: 003497 Surveyors: Linda Dubak, R.N. Public Health Nurse Surveyor ReBecca Lair, LCSW Medical Surveyor Carmel Ambulatory Surgery Center is in compliance with 410 IAC 15-2.5-3, Medical records, storage, and administration, Indiana Ambulatory Surgery Center Licensure Rules. QA: claughlin 08/06/12	S 000		